



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

Twin City Fire Insurance Co

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-10-0913-01

MFDR Date Received

October 7, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility \$3885.94 because this account meets outlier criteria. Based on their payment of \$1530.55, a supplemental payment of \$2355.39 is due."

Amount in Dispute: \$2,355.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier was notified of this medical fee dispute on October 8, 2009, but no response was submitted.

Response Required by: Twin City Fire Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2008	Outpatient Hospital Services	\$2,355.39	\$2,355.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement guidelines for professional medical services.

4. 28 Texas Administrative Code §133.4 provides for written notification to health care providers of contractual agreements for informal and voluntary networks.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 18, 2008

- 45 (45) CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
- 97 (97) PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE
- BL ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS-AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR QUESTIONS REGARDING CONTRACTUAL REDUCTIONS, PLEASE
- BL TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
- BL SECTION 413.042 OF THE TEXAS LABOR CODE PROHIBITS A PROVIDER FROM BALANCE BILLING AN INJURED WORKER FOR WORKERS' COMPENSATION COMPENSABLE SE
- 96 (96) NON-COVERED CHARGE(S)
- 18 (181) PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE

Explanation of benefits dated July 29, 2009

- 45 (45) CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
- 96 (96) NON-COVERED CHARGE(S)
- 97 (97) PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE
- 18 (181) PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE
- BL THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 (45) "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT and BL - ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS-AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR QUESTIONS REGARDING CONTRACTUAL REDUCTIONS, PLEASE ." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on August, 26, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and

supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 36415, date of service November 3, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
- Procedure code 80053, date of service November 3, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.77. 125% of this amount is \$18.46. The recommended payment is \$18.46.
- Procedure code 85025, date of service November 3, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.86. 125% of this amount is \$13.57. The recommended payment is \$13.57.
- Procedure code 81003, date of service November 3, 2008, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.14. 125% of this amount is \$3.93. The recommended payment is \$3.93.
- Procedure code 71020, date of service November 3, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.57. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$24.05. The non-labor related portion is 40% of the APC rate or \$17.72. The sum of the labor and non-labor related amounts is \$41.77. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this line is \$41.77. This amount multiplied by 200% yields a MAR of \$83.54.
- Procedure code 77003, date of service November 3, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 64475, date of service November 3, 2008, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of \$449.34. This amount multiplied by 60% yields an unadjusted labor-related amount of \$269.60. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$244.07. The non-labor related portion is 40% of the APC rate or \$179.74. The sum of the labor and non-labor related amounts is \$423.81. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio multiplied by the billed charge of \$7,481.67 yields a cost

of \$1,451.44. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$423.81 divided by the sum of all APC payments is 67.44%. The sum of all packaged costs is \$2,911.74. The allocated portion of packaged costs is \$1,963.69. This amount added to the service cost yields a total cost of \$3,415.13. The cost of these services exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$2,673.46. 50% of this amount is \$1,336.73. The total APC payment for this line, including outlier payment, is \$1,760.54. This amount multiplied by 200% yields a MAR of \$3,521.08.

- Procedure code 64476, date of service November 3, 2008, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0204, which, per OPPS Addendum A, has a payment rate of \$147.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$88.71. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$80.31. The non-labor related portion is 40% of the APC rate or \$59.14. The sum of the labor and non-labor related amounts is \$139.45. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio multiplied by the billed charge of \$7,481.67 yields a cost of \$1,451.44. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$69.73 divided by the sum of all APC payments is 11.10%. The sum of all packaged costs is \$2,911.74. The allocated portion of packaged costs is \$323.09. This amount added to the service cost yields a total cost of \$1,774.53. The cost of these services exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$1,652.50. 50% of this amount is \$826.25. The total APC payment for this line, including outlier payment and multiple-procedure discount, is \$895.98. This amount multiplied by 200% yields a MAR of \$1,791.96.
- Procedure code 64476, date of service November 3, 2008, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0204, which, per OPPS Addendum A, has a payment rate of \$147.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$88.71. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$80.31. The non-labor related portion is 40% of the APC rate or \$59.14. The sum of the labor and non-labor related amounts is \$139.45. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio multiplied by the billed charge of \$7,481.66 yields a cost of \$1,451.44. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$69.73 divided by the sum of all APC payments is 11.10%. The sum of all packaged costs is \$2,911.74. The allocated portion of packaged costs is \$323.09. This amount added to the service cost yields a total cost of \$1,774.53. The cost of these services exceeds the annual fixed-dollar threshold of \$1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is \$1,652.50. 50% of this amount is \$826.25. The total APC payment for this line, including outlier payment and multiple-procedure discount, is \$895.98. This amount multiplied by 200% yields a MAR of \$1,791.96.
- Procedure code J1040, date of service November 3, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885, date of service November 3, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250, date of service November 3, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010, date of service November 3, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement

for other services, including outliers.

- Procedure code 93005, date of service November 3, 2008, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$24.79. This amount multiplied by 60% yields an unadjusted labor-related amount of \$14.87. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$13.46. The non-labor related portion is 40% of the APC rate or \$9.92. The sum of the labor and non-labor related amounts is \$23.38. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,575. The outlier payment amount is \$0. The total APC payment for this line is \$23.38. This amount multiplied by 200% yields a MAR of \$46.76.
4. The total allowable reimbursement for the services in dispute is \$7,275.01. The amount previously paid by the insurance carrier is \$1,423.00. The requestor is seeking additional reimbursement in the amount of \$2,355.39. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,355.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,355.39, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 11, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.